

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170

66828

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: *Calvert.*

County

*Prince Frederick Md*

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? -----

Hospital, Institution, or street address where death occurred:

*Calvert County Hospital, Prince Frederick, Md.*

How long in hospital or institution? -----

## 3. (a) FULL NAME

*Norris Harkness Boburne, Jr.*

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*M.**W.**DIVORCED*

6. (b) Name of husband or wife

*DIVORCED*

7. Birth date of deceased (mo. day. yr.)

*July 26, 1919*

6. (c) If alive, give age years

8. AGE: Years

Months

Days

If less than one day

*25**11**27**hrs.**min.*

9. Birthplace

*Chicago, Illinois*

(Town, county, and state)

10. Usual occupation

*U. S. Navy*

11. Industry or business

*Naval Service*

MOTHER FATHER

*unknown*

13. Birthplace

*unknown*

14. Maiden name

*unknown*

15. Birthplace

*unknown*

16. Informant

*Hospital Records*

Address

17. Removal

Date thereof

7-26-45  
(month) (day) (year)

Cemetery or crematory

*Chicago, Ill.*

Location

*Geo. W. Wise Co. Inc.*

18. Funeral director

Address

*2900 Mass. Ave. Washington, D. C.*

19. 7-26

19. 45

(Date rec'd by registrar)

*Mary Cladott Smith*

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

*WASHINGTON, D. C.*

City or town

*WASHINGTON, D. C.*

(If outside city or town limits, write RURAL and give nearest town)

Street No.

*RECEIVING STATION, NAVY YARD*

(If rural, give LOCATION)

2. (a) If veteran, name war

*WORLD WAR II*

V

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH

*23. July 1945*

at 8 45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*22 July 1945* to *23 July 1945*and that I last saw him alive on *23 July 1945*

Immediate cause of death

*Fracture of skull*Due to *auto accident*

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of *23 July 45*

Where did injury occur?

(City or town) *Chevy Chase, Calvert, Md.* (County) *Calvert* (State) *Md.*

Injured at home, farm, industry, public place (where?)

*State Card*

Means of injury

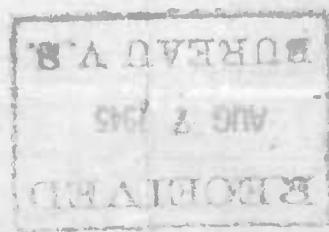
Injured at work?

23. SIGNATURE

*Herbster, M.D.*

M. D. or other

Address *3015 Connecticut Avenue, N.W., Washington, D.C.* Date signed *23 July 45*



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (R3)

06829

## CERTIFICATE OF DEATH

Reg. Dist. No. 51

## 1. PLACE OF DEATH:

County

Calvert

City or town

Towson Mallard Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

M C

5. Color or race

6.(a) Single, married, widowed, or divorced

S

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age years

July 12, 1934

8. AGE:

Years

Months

Days

If less than one day

11 4 18

hrs.

min.

9. Birthplace

(Town, county, and state)

Towson

10. Usual occupation

Farmer

11. Industry or business

FATHER Father

12. Name

Talbot Freeland

13. Birthplace

Towson

MOTHER Mother

14. Maiden name

Cathie Horne

15. Birthplace

Towson

16. Informant

Talbot Freeland

Address

Towson Mallard

Burial

(Burial, cremation, or removal. Which?)

Date thereof

7-4-45

(month) (day) (year)

Cemetery or crematory

Mt. Hope

Location

Calvert

18. Funeral director

P. E. Sevill

Address

Baltimore Frederick

19. Date rec'd by registrar

July 9 1945

I. N. King

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Towson

County

Calvert

City or town

Towson

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

7/1/1945 at 12:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

13 10 19

and that I last saw him alive on

19

Immediate cause of death

Drown

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Accidental Date of

Where did injury occur?

Towson Mallard Date of

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Place

Means of injury

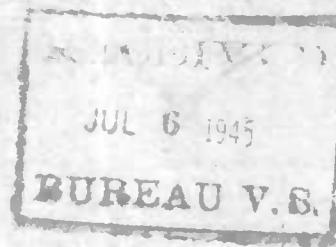
Injured at work?

23. SIGNATURE

Dr. Howard M. D. or other

Address

Dwight D. Eisenhower Date signed



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 172

## CERTIFICATE OF DEATH

06830

Reg. Dist. No.

51

## 1. PLACE OF DEATH:

County

Cabinet

City or town

Near Solomons, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Jesse W. Harrington

## 4. Sex

## 5. Color or race

## 6. (a) Single, married, widowed, or divorced

Male

White

Married

## 6. (b) Name of husband or wife

Annie Harrington

## 7. Birth date of deceased (mo., day, yr.)

Sept. 19, 1905

1904

## 6. (c) If alive, give age

7

years

## 8. AGE:

Years

Months

Days

If less than one day

40

.hrs.

min.

## 9. Birthplace

Montross, Va

(Town, county, and state)

## 10. Usual occupation

Salesman

## 11. Industry or business

## FATHER

C. C. Harrington

## 12. Name

Va

## 13. Birthplace

Va

## MOTHER

Juanita Porter

## 14. Maiden name

Va

## 15. Birthplace

Va

## 16. Informant

C. T. Harrington

## Address

7. Davissile St.

## 17. Cremation

Arlington, Va

## (Burial, cremation, or removal. Which?)

Date thereof 7-14-45

(month) (day) (year)

## Cemetery or crematory

Cedars Hill

## Location

Baltimore, Md

## 18. Funeral director

A. A. Harkness &amp; Sons

## Address

Mutual, Md

## 19. Date rec'd by registrar

July 13, 1945

A. D. King

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Va

County

Arlington

City or town

7. Davissile St.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

?

(If rural, give LOCATION)

2.(a) If veteran, name w/

?

## 3. (b) Social Security Number

?

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

July 4, 1945, at ?

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h. alive on

19.

## Immediate cause of death

Bronch

## Due to

## Due to

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

7-4-45

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury (fall off roof) Injured at work?

## 23. SIGNATURE

H. W. Ward Date signed

Reg. No. 1945-3748 M. D. or other

Address: 101 W. Pratt Street, Baltimore, Md.



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 103

06831

## CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH: Calvert  
 County Calvert  
 City or town Lindley (Flag Pond)  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? \_\_\_\_\_  
 Hospital, institution, or street address where death occurred: \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

3. (a) FULL NAME Edward F. Hefflin

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced ?

6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) May 10 1923 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: 23 Month May If less than one day 10 hrs. \_\_\_\_\_ min. 0

9. Birthplace Roseville, Va  
 (Town, county, and state)

10. Usual occupation ?

11. Industry or business ?

12. Name Ben Hefflin

13. Birthplace ?

14. Maiden name Bindie Jacob

15. Birthplace ?

16. Informant Ben Hefflin  
 Address West, DC

17. Burial & Removal Date thereof July 4<sup>th</sup> 1945  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory \_\_\_\_\_  
 Location Frederickburg, Va

18. Funeral director A. A. Neumann & Son  
 Address Mutual, Inc

19. 7-4 1945 2.1. King  
 (Date rec'd by registrar) (Date signed) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Calvert County Calvert  
 City or town 522 W. 28th St. 48  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_ (If rural, give LOCATION) ?

2.(a) If veteran, name war ?3. (b) Social Security Number 3

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1945 at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ to \_\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_

Immediate cause of death Stroke

DURATION

Due to Found 245 pm 7/4/1945

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

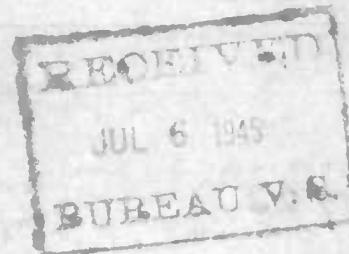
Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date 7/4/45Where did injury occur? One Pt. Club (City or town) Calvert (County) MD (State)Injured at home, farm, industry, public place (where?) One Pt. Club Calvert MDMeans of injury Car Injured at work? No23. SIGNATURE H. HefflinLast feed 2:15 KingM. D. or other None Date signed 7/4/45Address 522 W. 28th St. 48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77

16832

## CERTIFICATE OF DEATH

Reg. Dist. No. 51

## 1. PLACE OF DEATH:

County Cabaret  
City or town Port Republic  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Edmund C. Johnson

4. Sex <u>m</u>	5. Color or race <u>W</u>	6. (a) Single, married, widowed, or divorced <u>S</u>
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6. (b) Name of husband or wife:

7. Birth date of deceased (mo., day, yr.) Oct. 17, 1870  
.....(c) If alive, give age 1 years

8. AGE: Years <u>74</u>	Months <u>9</u>	Days <u>14</u>	If less than one day hrs. <u></u> min. <u></u>
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9. Birthplace Franklin, W. Virginia  
(Town, county, and state)10. Usual occupation Retired11. Industry or business MOTHER FATHER 12. Name John N. Johnson13. Birthplace West Virginia14. Maiden name Phoebe Johnson15. Birthplace West Virginia16. Informant Jameson SedgwickAddress Port Republic, Md17. Buried Date thereof Aug. 11, 1945  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Huntingburg, IndianaLocation Medical18. Funeral director A. G. Karpfus & SonAddress Mt. Pleasant, Md19. 8-1 1945 Date rec'd by registrar L. M. King Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Cabaret  
City or town Port Republic  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.   
(If rural, give LOCATION) no

2.(a) If veteran, name war 

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 31, 1945 at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1942 to July 1945  
and that I last saw him alive on July 27, 1945

Immediate cause of death

Generalized arteriosclerosis 2 or 3  
& decubitus ulcer years

DURATION

Due to

Due to

Other conditions Congenital Spina

(Include pregnancy within 3 months of death)

Major findings of operations

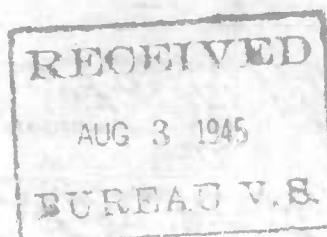
Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide  Date of Where did injury occur?  (City or town)  (County)  (State)Injured at home, farm, industry, public place (where?) Means of injury  Injured at work? 23. SIGNATURE Edmund C. Johnson M. D. or other Address Baltimore Frederick Date signed 8-1-45



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 933

06833

## CERTIFICATE OF DEATH

Reg. Dist. No. 50

## 1. PLACE OF DEATH:

County Cabret

City or town Columbia

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M

W

M

6. (b) Name of husband or wife

Sarah Jane Loe

7. Birth date of deceased (mo., day, yr.)

May 30, 1863

6. (c) If alive, give age 79 years

8. AGE:

Years

Months

Days

If less than one day

82

1

19

hrs.

min.

9. Birthplace

Newport

R. I.  
(Town, county, and state)

10. Usual occupation

Seaford Packer

11. Industry or business

12. Name

Annie A. Loe

13. Birthplace

N. J.

14. Maiden name

Annie A. Loe

15. Birthplace

N. J.

16. Informant

Rupert Loe

Address

Solomons, Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof July 22, 1945  
(month) (day) (year)

Cemetery or crematory

Solomons M. F.

Location

Solomons, Md

18. Funeral director

A. A. Starkness &amp; Son

Address

Baltimore, Md

19. Date rec'd by registrar

1945

Ave. S. Carter

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Cabret

City or town

Solomons

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

No

## 3. (b) Social Security Number

no

## MEDICAL CERTIFICATION

20. DATE OF DEATH

July 19

19

at 5:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 19, 1945, to

19

and that last saw h. alive on

19

Immediate cause of death

Acute Cardiac Failure

DURATION

Due to: Debilitative  
Heart Disease

Due to:

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

## AUTOPSY RESULTS

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. A. Loe

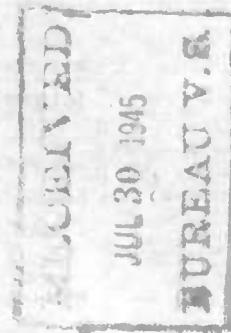
M. D. or other

Address

Jessie Loe

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 426

06834

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

## 1. PLACE OF DEATH:

County..... Calvert County

City or town..... Owings, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 months

Hospital, institution, or street address where death occurred:

Owings, Cal. Co. Maryland

How long in hospital or institution?

## 3. (a) FULL NAME

Edith Mary Lane

## 3. (b) Social Security Number

## 4. Sex

Female White Married

## 6. (a) Name of husband or wife

John Douglas Lane, Jr.

March 15, 1914

6. (c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.) March 24, 1916

8. AGE: Years 29 Months 3 Days 10 If less than one day hrs. min.

9. Birthplace..... Silver Spring, Md.

(Town, county, and state)

10. Usual occupation..... Housewife

## 11. Industry or business

12. Name..... Lloyd Thomas Clark

13. Birthplace..... Silver Spring, Md.

14. Maiden name..... Helen Mary Schriener

15. Birthplace..... Silver Spring, Md.

16. Informant..... John Douglas Lane, Jr.

Address..... Owings, Cal. Co. Md.

17. (Burial, cremation, or removal. Which?) Date thereof..... July 6, 1945

(Cemetery or crematory) Fort Lincoln Cemetery

Location..... Bladensburg Rd., Md.

18. Funeral director..... Warner E. Pumphrey

Address..... Silver Spring, Md.

19. (Date rec'd by registrar) 19 V. 1 (Signature) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Calvert

City or town..... Owings (If outside city or town limits, write RURAL and give nearest town)

Street No..... Route 416 (If rural, give LOCATION)

## 2.(a) If veteran, name war.....

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

3 July 1945 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2 July 1945 to 3 July 1945

and that I last saw her alive on 3 July 1945

## Immediate cause of death.....

abdominal hemorrhage

bleeding

Due to..... ruptured ectopic preg.

## Due to.....

## Other conditions.....

(Include pregnancy within 8 months of death)

## Major findings of operations.....

Date of op. ....

## Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of ....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

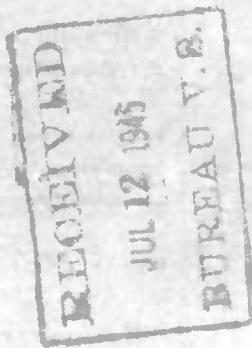
Injured at home, farm, industry, public place (where?) ....

## Means of injury.....

Injured at work? ....

## 23. SIGNATURE.....

M. D. or other ..... Address..... Huntingtown Date signed 3 July 45



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50.

07429

## CERTIFICATE OF DEATH

Reg. Dist. No. 50.

## 1. PLACE OF DEATH:

County Cabaret

City or town Solomons

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Leon Lushy

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced S

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) May 6, 1904

6. (c) If alive, give age years

8. AGE: Years 41 Months 2 Days 16 If less than one day hrs. 00 mila.

9. Birthplace Cabret, Md

(Town, county, and state)

10. Usual occupation Guard (Mine Warfau)

Text Stafin Solomons

11. Industry or business

MOTHER FATHER

12. Name Everett W. Lushy

13. Birthplace Cabret Co., Md

14. Maiden name Eliza E. Readmond

15. Birthplace St. Louis Co., Md

16. Informant Guy Lushy

Address Solomons, Md

17. Burial Date thereof July 24, 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Solomons M. E.

Location Solomons, Md.

18. Funeral director A. A. Harkness Son

Address Mutual, Md.

19. (Date rec'd by registrar) July 24, 1945 A. E. Foster

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md

County Cabret

City or town Solomons

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war N

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 22, 1945 at 5:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 19 45 to July 19 45 and that I last saw him alive on July 22 1945

Immediate cause of death Cancer of prostate

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Prince Frederick Date signed July 24, 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77

## CERTIFICATE OF DEATH

06835  
Reg. Dist. No. 52

## 1. PLACE OF DEATH:

County *Calvert*City or town *Oriole*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

*George William Oriole*

4. Sex

*M*

5. Color or race

*W*

6. (a) Single, married, widowed, or divorced

*W.*

6. (b) Name of husband or wife

*Ida Oriole*6. (c) If alive, give age *71* years

7. Birth date of

deceased (mo., day, yr.)

*March 22 1871*

8. AGE:

*74*

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

*W*

(Town, county, and state)

10. Usual occupation

*Farmer*

11. Industry or business

*Thomas Oriole*

MOTHER FATHER

12. Name

*Thomas Oriole*

13. Birthplace

*W*

14. Maiden name

*Ellen Carpenter*

15. Birthplace

*Missouri*

16. Informant

*Wm. Edith Keat*

Address

*Oriole W*

Burial

*Burial*

Date thereof

*July 22 - 45*

(month) (day) (year)

Cemetery or crematory

*Friendship Cemetery*

Location

*Frederick, A.A.C. Md.*

18. Funeral director

*W. H. Hutchins*

Address

*Oriole, Md*

19. Date rec'd by registrar

*July 21 1945*

19. (Date rec'd by registrar)

*Grace Hutchins*

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

*W*

County

*Calvert*

City or town

*Oriole*

(If outside city or town limits, write RURAL and give nearest town)

Street No.

*W*

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

*7/20*

1945 at 6:00 A.M.

21. CERTIFY that death occurred on the date above stated: that I attended deceased from

*July 14*1945 to *7/20*

1945

and that I last saw him alive on *7/19*

1945

Immediate cause of death

*arteriosclerosis*

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

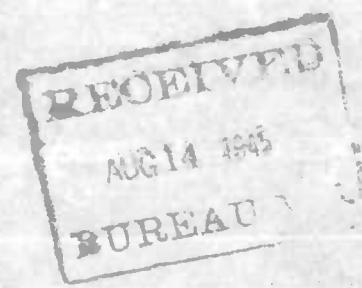
23. SIGNATURE

*Hugh W. Ward*

M. D. or other

Address

*Oriole, Md*Date signed *7/20/45*



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

## CERTIFICATE OF DEATH

1683 Reg. Dist. No. 52

## 1. PLACE OF DEATH:

County *Calvert*  
City or town *St. Paul*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

*Charles C. Sellers*

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white Married

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) *Oct. 23, 1884*

6. (c) If alive, give age

years

8. AGE: Years *61* Months  Days  If less than one day  hrs.  min. 9. Birthplace *South Carolina*  
(Town, county, and state)10. Usual occupation *Carpenter*

11. Industry or business

12. Name *unknown*13. Birthplace *unknown*14. Maiden name *unknown*15. Birthplace *unknown*16. Informant *Charles C. Sellers*Address *1025 North Filmore*17. Removal *Death* Date thereof *July 9, 1945*  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory *Hartsville, S.C.*Location *Hartsville, S.C.*18. Funeral director *Charles C. Sellers*Address *Arlington Va*19. Date rec'd by registrar *July 8, 1945*

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Arlington Va* County City or town  (If outside city or town limits, write RURAL and give nearest town)Street No. *1131 North Quincy Ave*

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH *7/8*

1945 at 1210 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw him alive on *July 9, 1945*Immediate cause of death *Stroke*

DURATION

Due to Due to Other conditions 

(Include pregnancy within 8 months of death)

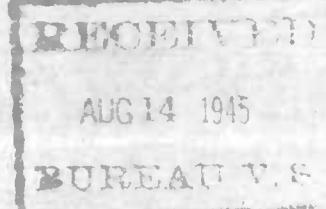
Major findings of operations Date of op. Autopsy results 

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *accident* Date of *7/8/45*Where did injury occur? *St. Paul Cem. and Crem.* (City or town) (County) (State)Injured at home, farm, industry, public place (where?) *Day alone*Means of injury *from* Injured at work? *no*23. SIGNATURE *Hugh W. Ward*M. D. or other *Dept. of Med. Comm.* Date signed *7/8/45*Address *Springfield, Va*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



✓ PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 470

16837

## CERTIFICATE OF DEATH

Reg. Dist. No. 52

1. PLACE OF DEATH: Calvert  
County Dunkirk

City or town Dunkirk  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME Lucile H. Young

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single

8. (b) Name of husband or wife.

7. Birth date of deceased (mo., day, yr.) Febr 7 1889 8. (c) If alive, give age years 19 years

8. AGE: 56 Years 5 Months 7 Days If less than one day hrs. min.

9. Birthplace Calvert Co.  
(Town, county, and state)

10. Usual occupation St. R. Labor

11. Industry or business

MOTHER FATHER James Peel

13. Birthplace Calvert

14. Maiden name Margrett Young

15. Birthplace Calvert

16. Informant Lucile Young

Address Dunkirk, Md.

17. Burial Burial Date thereof July 10 1945  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Halls Creek

Location Dunkirk, Md.

18. Funeral director J. S. Johnson

Address Indianapolis

19. Date record by registrar July 8 1945 19. Date July 8 1945 Grace Hutchins  
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Md. County Calvert

City or town Dunkirk  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 100  
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1945 at 5:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19. and that I last saw h. i.m. alive on 19. 4:45

Immediate cause of death Pneumonia

Due to Ca of lung -

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide  Date of

Where did injury occur?  (City or town)  (County)  (State)

Injured at home, farm, industry, public place (where?)

Means of injury  Injured at work?

23. SIGNATURE J. C. Sett / VILLARDO

M. D. or other

Address Prince Frederick Date signed 7/8/45

